Response to Charles Ornstein from Scott Fishman December 15, 2011

General Statement:
My career has focused on advancing treatment for patients in pain, including the safe and effective use of opioids. My positions on opioids have significantly evolved since I was initially taught, early in my training, that opioids were essentially safe when used for pain. Prior to the emergence of conclusive data concerning the serious risks associated with opioid therapy, I saw that these drugs being widely prescribed without physicians being educated about safe use and appropriate outcomes related to improved quality of life for patients. That recognition was the impetus for my becoming actively involved in physician education on safe use of opioids.

Gradually, my views have evolved as safety data has emerged showing increased risk with opioids. I believe you'll see this evolution in my positions over the years. For instance, in 2002, I was one of the first in the pain field to highlight the potential dangers associated with methadone, which is now all too commonly involved in unintended overdose deaths. I also fought for prescription monitoring programs to be designed as physician tools to help doctors identify doctor shoppers and problematic patients prior to writing prescriptions for controlled substances.

When consciousness began to rise around potential physician conflicts of interest with industry relationships, I changed my practices accordingly. This change occurred at the same time that many academic centers made similar changes intended to either avoid industry funding or keep it unrestricted and at arms length. Prior to this, industry relationships were the norm, as they still are for many practicing physicians. I have tried my best to balance my role in advancing safe and effective pain care with the real-world costs of providing physician education.

Questions
1) CDC director Dr. Thomas Frieden recently called opioid painkillers "highly addictive" and a treatment of last resort. In your presentations and articles, you are far more upbeat about the drugs. How do you reconcile these two positions?

Response – Your characterization of my presentations and articles on opioids as being "upbeat" is incorrect – I would not say that I am "upbeat" at all about the current environment, in which too many people are using opioids inappropriately. I have raised concerns about opioids for years and have publicly advocated for increased vigilance, safety and risk management. My views of opioid prescribing have evolved in step with the emerging evidence of prescription drug abuse and unintended overdose deaths.

There is no doubt that medicine must address pain. Opioids represent only a small part of the spectrum of options for mitigating pain, but they carry a disproportionate level of risk. The statistics on opioid-related abuse, diversion, morbidity and mortality are

unacceptable—but I believe this is a serious problem we can resolve the same way we have approached many other treatments that have significant risks but also benefits when the treatment is used wisely by trained providers. The key ingredient in this solution is physician education, which is why I'm committed to it. I see a future with much more education for medical students, nurses and all clinicians involved in delivering healthcare on pain-related assessment, treatment-risk management, drug abuse and addiction. I also see major changes such as rescheduling hydrocodone (Vicodin) as a schedule II drug (the most risky category), and even nationally mandated education of all prescribers by the DEA. Ironically, doctors and patients will likely react poorly to both of these initiatives, but I believe steps like these are exactly what we have to do to make prescribing of all controlled substances available to those for whom it is safe and effective.

Opioids are addictive but I doubt that most medical leaders would agree that they are *only* to be used as a last resort. I believe opioids should only be used when the benefits outweigh the risks – when less risky and reasonably effective options have been tried. For instance, it would not make sense to use a treatment that is more risky than opioids simply because opioids are only to be used as a last resort. As just one example, a patient at the end of life who is in severe pain may not be given acetaminophen even though this drug may have less risk -- because the chance of it working in this setting is low. In other cases, a careful prescriber might try a potentially less effective drug because it is safer and then consider incrementally riskier drugs if it doesn't work. Medicine is all about risk management. Physicians always have to balance risks with benefits. Unfortunately, until recently, this was never emphasized around the use of opioids or controlled substances in general.

The practice of medicine hinges on risk management, which is often a balancing act. Treating pain often presents clinicians with significant challenges — not least of which is the fact that pain is always subjective and none of us can prove the existence or measure the subjective intensity of a patient's pain. Another dilemma is that opioids are the most potent and reliable pain relievers, but they are not a panacea. Opioids do not work for all pain, or for all patients; they may offer relief for some and not others, and they may pose adverse effects ranging from mild to life threatening. The primary clinical goal is to balance the legitimate need to treat the harm that comes with ongoing pain with the equally compelling need to minimize other risks of harm, to both the patient and society at large.

Prior to the 1990s, opioid pain medications were viewed with skepticism and were often not employed, even when risks were thought to be low. This view gave way to the recognition that many patients were being under-treated for their pain, leading to increased interest in the clinical value of opioids, and a dramatic rise in rates of opioid prescribing for pain. Today, opioids are the most prescribed class of prescription medications in the United States. Escalating opioid prescribing rates coincided with a dramatic rise in diversion and nonmedical use of these powerful drugs with alarming

spikes in rates of addiction and unintended overdose deaths. This is perhaps due in part to lack of prescriber training, misconceptions that prescription medications are less dangerous than illicit drugs, proliferation of rogue Internet sites where consumers can purchase opioid medications without prescriptions, or via "online consultations" with real or bogus physicians, and the rise of dangerous "pill mills," where opioids are prescribed indiscriminately to anyone who will pay. A critical question that remains to be clarified is how much of this problem that is related to prescribers is due to MD's who falsely use the veil of being a physician to sell drugs through pill-mills and how much is due to well-intended but under-informed or under-educated prescribers who over-prescribe opioids for either legitimate patients in pain or individuals they believe to be legitimate patients. The former makes big news and deserves to be prosecuted criminally, and the latter must be either removed from prescribing or re-educated on how to prescribe responsibly.

Despite the undeniably dire statistics that reveal the scope of devastation caused by inappropriate use of opioid medications, clinicians still face the challenge of balancing the real need for pain control with the need to minimize and manage the risks associated with pain management, including use of opioid analgesics. I believe that this balancing act is not so different from the decisions required when clinicians use many other potentially risky pharmacological therapies. Solid medical practice is founded upon making rational and individualized decisions based on risk-benefit analyses. Clinicians routinely use dangerous treatments -- such as, chemotherapy, NSAIDS, and even insulin, to cite just a few examples -- and we do so only when the potential benefits outweigh the risks. We use great care to deliver these risky therapies safely. The challenge posed by opioid analgesics is that not only are they potentially dangerous for patients, they are highly sought-after for abuse. Over the recent past, we have learned that this makes the risks of opioids higher and poses a compensatory need for real benefits to justify such high risk.

Consumers need to know that many indispensible drugs have high risks, but over time the medical community has established safe parameters for their use in appropriate cases. In the early days of using general anesthesia, anesthesia-related morbidity and mortality occurred at unacceptable rates. Many thought anesthesia was too dangerous because clinicians had not yet learned how to use this tool safely.

Opioids are currently widely over-used. Their use needs to be substantially curtailed to levels that are proportionate to their risk. However, opioids are neither inherently "good" nor inherently "bad." I see no need for anyone to be "pro" or "con" when it comes to opioids. I think everyone should be able to agree that we must support the use of opioids in those cases where it is in the patient's best interest and oppose it when it is not. Such cases are clearly far less common than the current level of usage in the United States. Prescribers must weigh the potential risks and benefits of opioid therapy against alternative treatment options, as well as the risk of non-treatment. In daily practice, that means a prescriber may be "pro" opioid for one patient and "con" for another.

2) When doctors have been criminally accused of indiscriminately prescribing opioids, you have several times said that you were concerned that such prosecutions would have a chilling effect on other doctors. Given what you have written about the proper way for doctors to treat patients in pain, shouldn't those who break the rules be held accountable?

Response – Yes, I believe that doctors who break the rules should be held accountable. In fact, I have assisted the DEA, Attorney General's Office, and medical boards on cases against physicians who are harming patients and have worked in other ways to help fight prescription drug abuse, such as establishing a prescription drug monitoring database in California to identify instances of "doctor shopping" as well as leading the largest study conducted on such a database to show the high levels of patients receiving the same opioid from multiple prescribers and multiple pharmacies.

I believe that some criminal prosecutions have been justified, as it appears that these physicians were acting in the best interest of themselves and not the patient – Pill Mills are a good example. These are drug dealers pretending to be doctors, even if they have medical licenses. On the other hand, there are cases of doctors who appear to have been trying to help their patients but used very poor judgment in prescribing opioids. Some of these physicians were not drug dealers and needed to be dealt with and even prosecuted by the medical board. The difference between these kinds of cases and criminal prosecution hinges on the criminal's intent to do harm. This intent is clear in some physician cases, and in many others it simply is not clear. In one highly publicized case, I helped the American Academy of Pain Medicine produce an amicus brief to appeal the initial trial of Dr. William Hurwitz. Without looking closely, it may appear that I was supporting Dr. Hurwitz, but the brief I supported was focused solely on a procedural issue in the trial that we felt would have a long-lasting negative precedent for future legitimate physicians. The problem was that the judge refused to explain to the jury the difference between being an incompetent physician who causes harm and being a medical doctor acting as a drug dealer. This issue was about giving physicians due process under the law, which is in the greater interest of society. Other organizations agreed, as did the federal court of appeals, which overturned the verdict on this one procedural point. Dr. Hurwitz was retried with appropriate jury instructions and found guilty, which I had no problem with.

Unlike a criminal court, the medical board is designed to understand these nuances, and they work with the attorney general in each state to deal with incompetent doctors with measures ranging from license suspension to prosecution. The medical board is designed to protect society by taking bad doctors out of the doctor pool and can also punish them. Criminal prosecution of physicians makes a big splash in the media but, while most of these cases are based on practice that may be well beneath the standard of care, the criminal intent, or reckless disregard, in many of these cases is far from clear-cut. These cases are relatively rare but are widely publicized. It's only natural that criminal prosecution of incompetent physicians scares legitimate doctors; the very ones

that we need to treat the 116 million Americans (per the recent Institute of Medicine report) in chronic pain and the many more millions in other forms of pain every day. I do not think society wants the average well-intended and legitimate physician to feel prone to being mistaken as a criminal if they have a bad outcome from a potentially poorly conceived pain management treatment. We have established medical boards to handle this. Too many doctors feel that they should avoid treating pain to avoid getting in trouble.

We have grossly under-educated our physicians about pain, pain treatment, and effective treatment as well as the risks of treating pain. We don't need to scare them – we need to give them the tools to be safe and successful for their patients – exactly what has been done with other treatments that pose significant risk and which must be used only with good cause and great care.

3) Are you leaving an impression with the public that doctors that run pill mills should not be punished because the result may frighten other doctors or limit access to opioids for other patients?

Response – No. Doctors who run pill mills should be punished. But there is a substantial difference between criminals who run pill mills (who deserve criminal prosecution) and incompetent, uneducated, but well intentioned doctors whose actions in their patients' best interests result in harm. Medical boards are in place to remove these incompetent physicians from practice and punish them according to the law. Again, I have helped the DEA, Attorney General's Office, and medical boards on cases against physicians who are harming patients. I believe that my books, lectures, and other educational materials (as long as they are not taken out on context) reflect an evolution of embracing safety, risk management, as a counterbalance to any effectiveness that may be seen with the use of opioids. I neither believe that doctors are above the law, nor that pill mill pushers (they really are not doctors even though they may have MD degrees) should be protected in any way from criminal prosecution.

4) Your disclosures indicate that you had relationships with a number of pharmaceutical companies prior to 2007. At the current time, do you receive any financial remuneration from any company involved in the pharmaceutical or device industries?

Response – I do not currently receive any direct financial remuneration from any company involved in the pharmaceutical or device industries. I provided you with a statement accompanying my 2007-2011 disclosures that you requested. I am not sure how you took this in order to frame your question -- The statement was as follows:

I am enclosing my UCD Davis annual reports of compensated outside professional activities. For the past five years, I have had no financial relationships with pharmaceutical companies, except for two instances in 2008: 1) an educational lecture

for which Pfizer provided funding and in which I used my own educational content and industry had no role in my presentation and 2) a single day research meeting with NeuroMed. Neither of these companies was marketing opioids.

I have also served as president and chair of the board of directors of the American Pain Foundation from 2008-11 (a nonprofit patient advocacy organization that receives support from donations, private or government grants, as well as industry grants, some of which are from manufacturers of prescription opioids) for which I received no compensation. However, one time per year I am reimbursed for out-of-pocket expenses for coach airfare and cab fare for an annual board meeting. I have participated in numerous ACCME-certified continuing medical education activities yearly, for which I received market-rate honoraria. These programs were organized by academic health systems and/or medical professional organizations, and some of these programs independently obtained funding from commercial sources related to opioid prescribing. I have not accepted any funds directly from any commercial sponsors, and all funding was at arms length from me per ACCME guidelines. …Scott Fishman, MD

To avoid the perception of conflict of interest and in response to changes in pharmaceutical company guidelines that specifically began requiring physicians to use industry-developed educational materials, I stopped accepting educational opportunities and participating in advisory boards with pharmaceutical companies around 2006. Since 2006, I have had no direct financial relationships with industry, except for the two instances I noted in my statement above (neither were opioid manufacturers). Over these past years, I have rejected all other requests to participate in any program (speakers programs, advisory boards, consulting, or sponsored research etc.) that are directly funded by any pharmaceutical companies.

An unfortunate point of confusion is that some disclosure statements related to me, prior to approximately 2009, were taken from an out-of-date standard form that included every pharmaceutical company that I had any interaction with over the duration of my career. My practice had been to disclose all past relationships with no time limits. This list went out for time-limited disclosures and gave the false impression that these activities were current. We have attempted to correct as many of these outdated and/or incorrect disclosure statements as possible but many still exist as remnants of programs that may be found on the Internet.

5) How much money do you earn from delivering CME courses, lectures, webcasts, etc., some of which are supported by unrestricted grants from these companies? I don't see those on your university disclosures. Can you help me understand why?

Response – Receiving honoraria for ACCME-approved continuing medical education programs and lectures is permitted under University policy and accepted as part of the faculty member's scholarly and creative work. The University therefore does not require an accounting of honoraria received for ACCME-approved continuing medical education programs and lectures, and I have not maintained a list of the honoraria that I have

received when presenting at one of these programs. But I want be clear that any honoraria I am awarded for my educational presentations are market rate, which is to say they are given as a token of appreciation for my time and expertise and do not reflect the value of my time as a physician and university professor. In reviewing my 2011 calendar, it appears that over the past year I participated in 15 CME programs. I do not have an exact accounting of honoraria, but they roughly ranged from programs offering no honorarium to around $2,000. I believe six of the 15 programs offered no honorarium – and these were mostly local programs. The programs offering honorarium typically required greater travel, often across the country, and most required me to be away from my job for at least a day or two. This is typical of CME presentations that I am invited to make about once a month at various locations around the country.

6) How much of a difference is there between taking funds from a third-party CME company receiving grants from a drug company and taking funds from drugmakers themselves?

Response: This is a question you should take-up with the Accreditation Council for Continuing Medical Education (ACCME). The ACCME's Mission is stated as *the identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.* ACCME approved Continuing Medical Education is the widely accepted standard for appropriate arms-length distance between education programs and unrestricted industry funders. Universities and professional organizations widely rely on these guidelines to assure unbiased education. Institutions like Harvard, Johns Hopkins, AMA, and many if not most others who produce CME programs accept unrestricted grants from industry to help support their education programs as long as it meets ACCME standards. And even the FDA is now working with pharmaceutical companies that manufacture opioids to pay for the CME education that they believe physicians desperately need. Thus, I accept CME opportunities -- with or without honoraria-- to educate on safe prescribing and other aspects of pain management. I have no role in the financing of these programs and have no contact with the funders. In every case, the education I provide is my own content and completely under my control. Moreover, if you follow the content of my CME lectures on opioids, you'll find that I stress safety first and heightened restraint in opioid prescribing.

7) How much were you paid to write the Responsible Opioid Prescribing book? And what was the source of that funding?

Response - I have not received any payments for my work on this book from the Federation of State Medical Boards (FSMB) or anyone else, and have not received royalties from the publisher for any version of this book because I did not want my support of the book's principles to be viewed as being in the service of selling books. I avoided receiving funding for authoring *Responsible Opioid Prescribing*, explicitly to

avoid the perception of a potential conflict of interest in my authorship of this book or for the ongoing efforts of the FSMB to use the book in statewide physician-education initiatives.

8) Why are you stepping down as chairman of the APF?

Response - My term was due to expire in December 2010 and I expected to step down at that time. I was asked by the board of directors to stay on for one more year, which I did. I am stepping down now as I had planned.

9) Because you have been APF chairman and president since 2008, and a board member before then, I would like to know if you feel comfortable with the group's publications and lobbying statements, particularly in light of the increases in deaths, ER visits and treatment referrals attributable to opioids?

Response – I have not always agreed with APF positions and have had disagreements with some APF leaders and patient advocates about many issues in pain management, including the appropriate place of chronic opioid therapy. The APF does not necessarily represent my views, and I do not necessarily represent theirs. Nonetheless, I have always believed that patients in pain in the United States need strong patient advocacy, which APF has offered. Although I do not agree with all APF positions, I very much respect the perspective of people who suffer in pain. I recognize that we are all ultimately biased in our views – including patients who too often feel desperate for help and physicians like me who feel obliged to balance benefits with risks. Despite the potential conflicts, I think society and medicine are better off for hearing the voice of people who suffer with the diseases that medicine must try to treat.

Your question about “feeling comfortable” speaks to the crux of treating pain, because there is no comfortable ground to be found by anyone sincerely involved in the challenge of how to meet the needs of patients in pain while protecting them and society from risk. As I can assure you from close daily contact with patients, there is nothing remotely comfortable about chronic pain. It can devastate the lives of its victims, and often the lives of families that care for them. Being a physician to whom these patients turn to for treatment is also not comfortable. These patients have desperate physical and emotional wounds that cry out for relief. There are no risk-free options including treating or not treating. My sincere request of you is that you appreciate the complexities and conflicts inherent to treating chronic pain, particularly with opioids -- and to providing the much-needed education for the physicians who prescribe them.

Response to Charles Ornstein Question December 17, 2011

Q1) You indicate your own desire not to be conflicted by industry funding. As chairman, do you see a problem with APF receiving 88 percent of its revenue last year from industry?

A1. Currently, the only way for APF to do its work is through outside funding and most of it comes from industry. In my term as APF chair, the board of directors set a strategic goal to diversify as much as possible and develop additional funding streams. Nonetheless, at present APF 's advocacy and educational work would not be possible without funding through industry. The APF CEO has explained that APF creates projects and then solicits many potential funders for support – often support comes from many sources and there is an ethics policy to guide the process. I will leave this discussion to the CEO who you are in touch with.

Your questions suggest you believe that that industry has bought APF's positions on pain management and, although this may make a good story, it is not accurate. APF has advocated for a vast diversity of issues related to pain management spanning psychology and alternative medicine to surgery. Any emphasis on opioids is not due to industry support but because opioids are the pain relief option that has been targeted and most at risk to be limited from its current availability—unlike other analgesics which could be attacked such as high death rates from NSAIDs, overuse of procedures etc. Opioids are only one of many options for pain relief and patients have a right to demand treatments they feel will help them. It's physicians who bear the responsibility of making sure the treatments they prescribe are safe. Especially vulnerable populations, like patients in chronic pain who have limited treatment options, are naturally going to want to retain access to any of their options. So it's not surprising that these patients push back when treatment options such as opioids are being attacked and restricted. **Physicians are responsible for safe prescribing, not patients**. The problem isn't patients demanding opioids – it's prescribers giving opioids to the wrong patients, in excessive dosages, and not stopping the medication when there is no evidence of benefit.

Conspiracy theories around pharmaceutical companies buying off advocacy groups miss the much more likely cause for the problem of over-prescribed opioids; the problem is that prescribers are largely under-educated on how to use long term opioid therapies -- not patients in pain who do not want their limited options reduced even further. Does anyone really believe that if industry paid a patient organization to demand more insulin than is healthy, that physicians would do it. This wouldn't happen because physicians are trained and "know better". I can assure you if your loved one had a chronic disease that produced severe ongoing suffering with limited options, you would want advocacy for them. But you'd also demand that your physician was fully trained and prepared to deliver safe and effective treatment. Hopefully, the public will see this part of the story and demand that medical students, residents and all doctors are fully trained -- the

recent Institute of Medicine Report and other major efforts are pushing us closer to this reality.

Q2) Given what you wrote about opioid overuse, is APF's aggressive defense of opioids ultimately harmful to the public understanding of pain and treatment?

A2. Your question suggests you are missing the main problem: prescribers of controlled substances have minimal training. Your questions suggest that you may believe that prescribers "know better" but over-prescribe anyway because of drug company propaganda or because patient advocacy groups push them to do so. I see no evidence that you are factoring in that medical schools or medical residencies simply did not train these physicians in the first place. Opioids are an essential part of the medical arsenal that can offer significant benefit as well as serious toxicity. These medicines can be effective for some and, like many risky medicines in the doctor's arsenal, can be used safely - but the physicians must be knowledgeable and must prescribe them responsibly.

Again, patients suffering with debilitating medical problems that have limited treatment options have every right to want strong medicines. It is the prescriber, who is licensed and registered with the DEA, who must weigh the risks vs. the benefits and use sound medical judgment to help a suffering patient. The abuse problem isn't due to patients advocating for pain control, it is in large part due to prescribers being grossly under educated about pain and responsible use of controlled substances. In the face of a public health crisis of under-treated pain (116 million Americans in chronic pain per the recent IOM report), and despite the epidemic of prescription drug abuse (per the CDC and FDA), prescribers find dealing with pain difficult because they are not trained, and its not surprising that they find it much easier to either just take a position of refusing to treat chronic pain or to just hand out a strong medication because they don't know what else to do. If you understand how doctors are trained, it's not surprising that many refuse to treat and many prescribe too much. It is a truly sad fact that pain is the most common reason patients see doctors, and doctors are grossly under-educated on how to assess or treat pain, and even less skilled in using controlled substances. Safer, more responsible prescribing would equate to far less use, much greater discretion in who is prescribed opioids, much clearer risk management, and clear end points from the treatment that clearly equate with improving function (which is roughly the opposite outcome of addiction).

I believe you will likely be able to go back and find some statements from the APF website and elsewhere, taken in isolation, that are dated and should be changed. However, APF has evolved like everyone else – the obvious examples are its PainSAFE program that highlights the consumer role in risk management, its current opioid policy that emphasizes safety as a pillar of treatment with opioids, and more. Your questions suggest you believe that the opioid problem is being driven by a conspiracy involving pharmaceutical companies and are missing the proverbial giant

elephant in the room -- which is the lack of prescriber education in pain assessment, treatment, and safety with controlled substances. That is why I wrote "Responsible Opioid Prescribing" for the Federation of State Medical Boards. I believe that if you took away the APF 10 years ago, the problem of prescription drug abuse would be no different today – because physicians were widely encouraged to treat pain without any of the skills and cautions needed to do it selectively and safely. Ask most doctors how much training they received in medical school on pain management and safe use of controlled substances – by and large, they will tell you they get almost none.

3) Can you provide examples of cases in which you testified on behalf of the AG, DEA or medical board? We were not able to find them in our search.

A3. I did not mention testifying - please re-read my previous responses. I said I assisted in cases against physicians – in fact I can't recall a case where I defended a physician in court. However, since you ask about testimony, I have attached my 2008 testimony to the FDA.

Q4) Given your disagreement with APF on some positions, can you explain why you felt comfortable being the group's chairman for the past 3 years and on the board for years before that?

A4. As I have said, APF does not represent my beliefs and I do not represent those of APF. My role as chair was not to impose my beliefs and I had only one vote amongst the 18 board members. I have not agreed with some APF positions but I do not believe I disagreed with any formal positions during my term as chair. Nonetheless, pain and pain management is not simple, with complexity ranging within medical, social, ethical and even spiritual realms. Disagreement is not only natural, but also required within a thoughtful organization. Despite any disagreement I might have, I believe in the APF's purpose, its vital role for people in pain, and it's evolving positions. APF has transitioned over the past 3 years and I suspect any member of the board or staff will tell you that I have been a strong advocate for raising the place of safety as a patient issue. During my term, APF conducted its first strategic planning process over a year period resulting in a commitment to diversify funding sources, it produced a position statement on opioids that emphasized safety as a primary concern in opioid use, it launched PainSAFE, a resource for helping to educate consumers on safe use of opioids and many other analgesic therapies, and it continued to broaden its areas of focus which includes surgical neuromodulation, a wide variety of non-opioid pharmacological options for pain, psychological therapies for pain control as well as alternative medicine. And APF has increasingly advocated for patient education as a means for enhancing safety in the use of all pain treatment options, including opioids and all other analgesic therapies. APF is evolving with the times but its responsibilities are vastly different than those of physicians charged with safe prescribing.